OLDER ADULT PERFORMANCE OUTCOME PILOT COMMITTEE MEETING SYNOPSIS November 9, 2000

Jim Higgins, Department of Mental Health (DMH), led introductions and reviewed the agenda (*Attachment 1*). Representatives from the following counties were present: Astrid Beigel, Laura Trejo, and Iris Aguilar (Los Angeles County); Mary Flett (Santa Clara County); Victor Contreras (Sacramento County); Sharon Lopez (Shasta County), and Luanna Smith (Tuolumne County). Jim Higgins, Karen Purvis, and Traci Fujita represented the DMH Research and Performance Outcome Development Unit (RPOD).

The following agenda items were discussed:

- County Reports. Pilot county representatives each provided a brief status report on their county's progress. All counties have now completed their second administration of the pilot instruments. As is true across the country, pilot counties experienced a considerable dropoff in collection of second administration data. The group agreed that this was a methodological problem (i.e., gathering longitudinal data, too much time between administrations) and not a problem of these particular instruments.

  Most pilot counties have started, and some are close to completion of, their individual summary reports. These reports are intended to briefly describe a county's pilot administration procedures and provide an evaluation of the instruments, particularly from the viewpoint of the clinicians. Los Angeles requested extra time because of their late start on implementation and staff shortages. Jim Higgins said he was aware that sometimes individual county circumstances caused unavoidable delays, but he requested that all reports be turned in as soon as possible. Jim also offered to provide final, cleaned pilot data files (with county and client ID's removed) at the next meeting to counties interested in doing further analyses on their own.

  During this part of the meeting, pilot participants reiterated that clients continued to like the instruments, but that some clinicians still felt it was burdensome paperwork. Participants felt that clinicians would be much more likely to see the usefulness of the extensive face sheet currently being developed.

- Comparison of National Data and Pilot Data. Karen Purvis handed out a revised version of the report comparing pilot demographic results with prevalence data from the general population. This version added a row using age 65 as a cutoff so pilot results could be better compared with federal data.

- Face Sheet Revisions. The committee again spent considerable time reviewing and revising the draft face sheet. Some areas were eliminated after discussion, and others were expanded or reworded to increase accuracy and reliability. The goal is to collect useful, non-redundant information that will facilitate the valid interpretation of outcome data. The committee concentrated on the format of the face sheet, risk factors important to this age group, and the issue of measuring cultural competence.

- The group discussed the overall format of the face sheet and suggested separating it into two parts: a basic client identification page for information that never changes (e.g., client gender, ethnicity, birthdate) and update pages for information that could change (e.g., administration type, marital status, health status).

- Committee members made several suggestions regarding additional risk factors to include on the face sheet. Risk factors were defined as variables that could be used to help interpret and give context to results. Laura Trejo offered to review a federal report describing risk factors in older adults and will e-mail RPOD staff the ones she feels are the top ten indicators of well-being. Eventually, after pilot testing, the total number of risk areas will be limited to the top three or four.

- Committee members revisited the issue of how to measure cultural competence, but were still unable to provide any specific questions. Cultural competence is difficult to operationalize since it encompasses many subtle issues. Language translations are a necessary part of addressing cultural competence – but translations alone are not sufficient. The group still felt that, at some point, we must rely on clinical staff to collect information in a culturally competent manner.

Even though many refinements are still needed, the group definitely felt the face sheet would enhance the credibility and utility of the Older Adult Performance Outcome System. Since it is still a draft and has yet to be piloted, they suggested that we not do too much pre-screening – but rather try out various questions to see how they worked in actual practice. The group also discussed the procedural problems that arise when trying to decide which group should send in the outcomes data when there were multiple providers for one client.

- Traci Fujita will try to incorporate these suggestions for modifying the face sheet and fax a copy to committee members before the next meeting.

- The next two meetings of the Older Adult Performance Outcome Pilot committee were scheduled: **Tuesday, December 12, 2000** and **Thursday, January 11, 2001**.